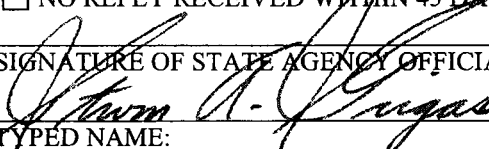
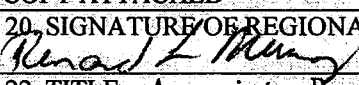


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 2004-018	2. STATE Florida
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2005	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.100 42 CFR 447.54(a)(2)		7. FEDERAL BUDGET IMPACT: a. FFY 2005      \$ 8,402 b. FFY 2006      \$11,121	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Page 32 Attachment 3.1-B, Page 31 Attachment 4.18-A, Page 1 Attachment 4.18-C, Page 1		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A, Page 32 Attachment 3.1-B, Page 31 Attachment 4.18-A, Page 1 Attachment 4.18-C, Page 1	
10. SUBJECT OF AMENDMENT: Adult Dental Services			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Will forward when received. <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Mr. Steven Grigas Acting Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308	
13. TYPED NAME: Mr. Steven Grigas		Attention: Kay Newman	
14. TITLE: Acting Deputy Secretary for Medicaid			
15. DATE SUBMITTED: July 7, 2004			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: July 12, 2004		18. DATE APPROVED: October 8, 2004	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2005		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Renard L. Murray, D.M.		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			

1/1/2005  
(10)  
(12.b) DENTAL SERVICES: For non-EPSDT recipients twenty-one years of age and older, services that are provided in accordance with 42 CFR 440.100 and 440.120(b) are limited to:

- a. Dentures. The dental services provided are limited to procedures related to dentures and those procedures necessary to seat the dentures. The recipient is limited to either a complete upper denture, a complete lower denture, or one complete set of dentures per lifetime. Partial dentures and replacement of broken or lost dentures are excluded from coverage. Repairs of dentures are covered services. Adjustments and relines are covered after three months for immediate dentures and six months for non-immediate dentures from the date of service.
- b. Oral and maxillofacial surgery for injury or disease when provided by a qualified oral surgeon (dentist).
- c. Emergency dental services are medically necessary emergency procedures to relieve pain or infection. The services are limited to emergency oral examinations, necessary radiographs, extractions, and the incision and drainage of an abscess.

Dental services limitations for EPSDT recipients, provided in accordance with 42 CFR 441.56, are listed in the EPSDT section.

Amendment: 04-018  
Effective: 1/1/2005  
Supersedes: 02-11  
Approved: 10/08/04

1/1/2005  
(10)  
(12.b)

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- b. Oral and maxillofacial surgery for injury or disease when provided by a qualified oral surgeon (dentist).
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Amendment: 04-018  
Effective: 1/1/2005  
Supersedes: 02-11  
Approved: 10/08/04

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State FLORIDA

- a. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determinations
	Deduct.	Coins.	Copay	
Hospital Services: Non-emergency services in the hospital emergency room.		X		Effective July 1, 2003, there is a five (5) percent coinsurance charge to recipients 21 years of age or older on Medicaid payments greater than \$0.00 through the first \$300 per date of service for non-emergency services rendered in a hospital emergency room. There is 0% coinsurance on Medicaid payments in excess of \$300. Providers are responsible for collecting the cost sharing charges from recipients not otherwise exempt. Providers cannot deny services to recipients who are unable to meet their cost sharing obligation. Authority for the maximum charge is 42 CFR 447.54(a)(2). All exemptions to cost sharing noted in 42 CFR 447.53(b)(1)-(5) apply.
Dental Services: Dentures and all services related to the provision of dentures.		X		Effective January 1, 2005, there is a five (5) percent coinsurance charge to recipients twenty-one years of age or older who are not institutionalized, receiving hospice care or enrolled in an HMO. The 5 percent coinsurance applies to the amount of Medicaid payment made for the services and not the provider's charges for services. Providers are prohibited from denying services to recipients who are unable to meet their cost sharing obligation. Basis for determination was the maximum charge offered at 42 CFR 447.54(a)(2). The exemptions to cost sharing noted in 42 CFR 447.53(b)(1)-(5) apply.

TN No. 04-018

Approval Date: 10/08/04

Effective Date: 01/01/05

Supersedes

TN No. 03-16

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State FLORIDA

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determinations
	Deduct.	Coins.	Copay	
Hospital Services: Non-emergency services in the hospital emergency room		X		Effective July 1, 2003, there is a five (5) percent coinsurance charge to recipients 21 years of age or older on Medicaid payments greater than \$0.00 through the first \$300 per date of service for non-emergency services rendered in a hospital emergency room. There is 0% coinsurance on Medicaid payments in excess of \$300. Providers are responsible for collecting the cost sharing charges from recipients not otherwise exempt. Providers cannot deny services to recipients who are unable to meet their cost sharing obligation. Authority for the maximum charge is 42 CFR 447.54(a)(2). All exemptions to cost sharing noted in 42 CFR 447.53(b)(1)-(5) apply.
Dental Services. Dentures and all services related to the provision of dentures.		X		Effective January 1, 2005, there is a five (5) percent coinsurance charge to recipients twenty-one years of age or older who are not institutionalized, receiving hospice care or enrolled in an HMO. The 5 percent coinsurance applies to the amount of Medicaid payment made for the services and not the provider's charges for services. Providers are prohibited from denying services to recipients who are unable to meet their share of cost obligation. Basis for determination was the maximum charge offered at 42 CFR 447.54(a)(2). The exemptions to cost sharing noted in 42 CFR 447.53(b)(1)-(5) apply.

TN No. 04-018

Approval Date: 10/08/04

Effective Date: 01/01/05

Supersedes TN No. 03-16